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No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 609 F. Supp. 1360. The opinion of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 2, 1987. The petition for a writ of certiorari was filed on May 2, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. (& Supp. III) 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary

[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.SC. (& Supp. III) 1395*oo*(a)(2) and (3)).

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo* (f) (1)); 42 C.F.R. 405.1875-405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. Petitioners are two hospitals that have been certified as providers of services under the Medicare program. In their cost reports for 1980 and 1981 petitioners computed their claims for malpractice insurance premium reimbursement in accordance with the regulation governing reimbursement for such costs. As the court of appeals observed, "[t]he hospitals' cost reports thus included a claim for reimbursement for malpractice insurance costs, but * * * effectuated a 'self-disallowance' " of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment

[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement" (Pet. App. 5a).

Together with more than 25 other Ohio hospitals, petitioners filed an appeal with the Provider Reimbursement Review Board challenging the regulation governing the reimbursement of medical malpractice insurance premiums. The Board found that it lacked jurisdiction over petitioners' claims because "the malpractice issue was not raised in the * * * cost report(s); nor have any amended cost report(s) been accepted by the intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (Pet. App. 52a). The Board stated that "the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item * * *. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction" (*id.* at 54a). Thus, "[w]hen the provider files a cost report, the particular cost must be claimed therein or [the provider must] state its claim and disclose its position on an issue which was not done in this case" (*ibid.*).[7]

Petitioners sought judicial review of the Board's determination, and the district court reversed (Pet.

[7] The Board permitted the hospitals that had raised the issue before the intermediary to seek direct judicial review of their challenge to the malpractice insurance cost reimbursment, finding that the Board lacked authority to decide the hospitals' claim that the regulation governing reimbursement was invalid (see 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)).

App. 29a-51a). It concluded that the Board's review of the intermediary's determination "need not be limited to costs claimed by the provider to the intermediary in the cost report" (*id.* at 34a).[8]

3. The court of appeals, in turn, reversed the district court's decision. Relying upon its prior decision in *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860 (1986), the court concluded that the Board lacks jurisdiction over "claims by providers who * * * self-disallowed reimbursement and * * * failed to challenge the Secretary's regulations before the fiscal intermediary" (Pet. App. 6a). The *Baptist Hospital East* court had observed that the contrary interpretation of the statute —permitting the Board to act where the provider did not claim reimbursement—"renders the second part of the jurisdictional grant meaningless" and "places an irrational gloss on the statute" (802 F.2d at 865). The construction of the statute adopted by the court instead requires a provider "to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board" (*ibid.*).[9]

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[8] The district court also invalidated the malpractice insurance cost reimbursement rule (Pet. App. 42a-59a).

[9] The court of appeals rejected petitioners' claim that a contrary result was required by this Court's decision in *Bowen* v. *Michigan Academy*, No. 85-225 (June 9, 1986). It observed that *Michigan Academy* "dealt only with the right to judicial review in the absence of meaningful administrative review procedures" (Pet. App. 6a). Here, by contrast, there is an administrative review scheme, and the issue is whether

ARGUMENT

The court below correctly concluded that the Provider Reimbursement Review Board lacks authority to consider reimbursement claims that are not raised before the fiscal intermediary, such as the claims advanced by petitioners here. We believe this Court should grant certiorari, however, because the petition presents a question of considerable importance to the administration of the Medicare program as to which there is a square conflict among the courts of appeals.[10]

1. The Medicare statute contains two grants of authority empowering the Provider Reimbursement Review Board to revise the amount of reimbursement awarded to a provider by its fiscal intermediary. First, the Board has "the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report" (42 U.S.C. 1395*oo*(d)). Second, it may "make any other revisions on matters covered by such cost report (includ-

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"the *steps* in [the administrative review] process * * * include submission of a 'claim' before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement" (*id.* at 7a (emphasis in original)).

With regard to the challenge to the malpractice reimbursement rule advanced by the hospitals that had properly preserved the issue, the court held that a newly-promulgated rule governing malpractice cost reimbursement could not be applied retroactively to the cost years at issue in this case. It therefore upheld the district court's award of additional reimbursement to these hospitals. Pet. App. 3a-4a.

[10] The same question is also presented in two other cases pending before the Court. See *North Broward Hospital District* v. *Bowen*, petition for cert. pending, No. 86-1986; *University of Cincinnati* v. *Secretary of Health & Human Services*, petition for cert. pending, No. 87-57.

ing revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making [its] final determination" (*ibid.*). The Secretary has concluded that these provisions authorize the Board to act upon a provider's claim for reimbursement only if the provider sought reimbursement for the particular cost before the intermediary or otherwise raised before the intermediary its contention regarding the reimbursability of the cost. See Pet. App. 54a; *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 8 (D.C. Cir. 1984). That interpretation of the PRRB's jurisdiction is eminently reasonable.

As a threshold matter, it is instructive to consider the other possible interpretations of the scope of the Board's statutory authority. The Board could be free to consider any cost reimbursement claim advanced by a provider, without regard to whether the cost was even mentioned in the provider's cost report. But the statute expressly states that the Board may only revise the intermediary's determinations "with respect to a cost report" and may only act with respect to other "matters covered by such cost report." An interpretation of the statute that made the contents of the cost report irrelevant would "effectively nullify the language in the statute that limits the PRRB's authority to affirm, reverse or modify reimbursements to 'matters covered by [a] cost report.'" *Community Hospital* v. *Health & Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985) (quoting *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 6).

The second possible interpretation of the statute would be to permit the Board to consider a provider's claim for reimbursement with respect to all cost

items disclosed to the intermediary in the cost report, even if the provider did not seek reimbursement for the particular costs. We submit that, for three basic reasons, the court below was correct in rejecting this interpretation of the statute and upholding the Secretary's view of the Board's jurisdiction. Pet. App. 5a-6a, 7a; see also *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262-1263; *North Broward Hospital District* v. *Bowen*, 808 F.2d 1405, 1408-1410 (11th Cir. 1987), petition for cert. pending, No. 86-1986; *Athens Community Hospital, Inc.* v. *Schweiker*, *supra*.

First, the Secretary's interpretation gives effect to both statutory grants of jurisdiction. If the Board's authority to act with regard to "matters covered by [a] cost report" were found to allow it to consider any claim for reimbursement—including claims not presented to the intermediary—then the grant of authority to review the intermediary's determinations respecting the cost report would be completely superfluous. It is much more logical to interpret the statute

> as allowing the PRRB to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), [only] when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.

Athens Community Hospital, Inc., 743 F.2d at 9; see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262.

Second, the Secretary's interpretation of the statute best comports with the rest of the statutory scheme. A provider may "obtain a hearing" before the PRRB if it is "dissatisfied with a final determination of the * * * fiscal intermediary" (42 U.S.C. (& Supp. III) 1395*oo*(a)). "It would be anomalous * * * to say that a provider can appeal only when 'dissatisfied' while allowing the provider to obtain review of an intermediary's refusal to reimburse the provider for a cost it did not even claim. * * * If a provider is unhappy with the reimbursement the intermediary allowed in such a case, it is the fault of the provider and not of the intermediary." *Athens Community Hospital, Inc.*, 743 F.2d at 6; see also *North Broward Hospital District*, 808 F.2d at 1409. Indeed, Congress indicated in other parts of the statute that the provider's presentation of its claim to the intermediary is an essential prerequisite to further review. See 42 U.S.C. (& Supp. III) 1395*oo*(f)(1) (emphasis added) (authorizing provider to obtain direct judicial review of "*any action of the fiscal intermediary* which involves a question of law or regulations" that the Board lacks authority to decide).

Third, allowing the provider to raise a reimbursement claim for the first time before the PRRB "would have significant adverse practical consequences" (*Athens Community Hospital, Inc.*, 743 F.2d at 6). If a provider revised its claim *after* the intermediary's issuance of the Notice of Program Reimbursement, it would " 'deprive [the PRRB] of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and [have the effect of] possibly substantially slowing the reimbursement process for other providers.' " *Id.* at 6-7 (citation omitted); see also

North Broward Hospital District v. *Bowen*, 808 F.2d at 1409 (allowing provider to seek review of costs not claimed before the PRRB "would result in the elimination of the administrative review process clearly provided for in the Medicare statute and regulations); *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d at 865 (provider "may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board").

For these reasons, "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (*North Broward Hospital District*, 808 F.2d at 1409-1410 (footnote omitted)).[11]

2. There is a square conflict among the courts of appeals regarding the question presented in this case. Three courts of appeals, including the court below, have concluded that the Provider Reimbursement Review Board has jurisdiction only "over costs that are specifically claimed [in the cost report] * * * as well

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[11] Petitioners argue (Pet. 11-12) that this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, No. 85-225 (June 9, 1986), supports their position. The Court held in that case that a statutory provision precluding judicial review of benefits determinations did not bar review of regulations governing the method by which those determinations are made. There is no claim here that judicial review is precluded. Instead, the question relates to the procedures governing the availability of review; specifically, whether a provider must raise its claims before the fiscal intermediary in the first instance. *Michigan Academy* is wholly inapposite.

as those cost issues [explicitly] raised by a provider prior to the intermediary's issuance of the [Notice of Program Reimbursement]." *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 5-6 (D.C. Cir. 1984); *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860, 865-866 (6th Cir. 1986); *Community Hospital* v. *Health & Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985).

Two courts of appeals have concluded that a health care provider may seek administrative and judicial review of a cost item identified, but not claimed, in its cost report. *Adams House Health Care* v. *Heckler*, 817 F.2d 587 (9th Cir. 1987); *St. Mary of Nazareth Hospital Center* v. *Department of Health & Human Services*, 698 F.2d 1337, 1346 (7th Cir.), cert. denied, 464 U.S. 830 (1983). The First Circuit has concluded that "the [PRRB] has the legal power to decide matters not raised" before the intermediary but that, as a matter of administrative discretion, "it is up to the [PRRB] in the first instance to decide whether it will not hear the * * * claim." *St. Luke's Hospital* v. *Secretary of Health & Human Services*, 810 F.2d 325, 330, 332 (1987).

Two panels of the Eleventh Circuit that have considered the question have reached somewhat conflicting conclusions. In *North Broward Hospital District* v. *Bowen*, 808 F.2d 1405 (11th Cir. 1987), petition for cert. pending, No. 86-1986, the court held that "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (808 F.2d at 1409-1410 (footnote omitted)). In *Tallahassee Memorial Regional Medical Center* v. *Bowen*, No. 85-3839 (11th Cir. May 5, 1987), on the other hand, the court concluded that a provider may seek judicial review of the failure to award such costs at least where the award of the costs is barred by regulation, on the ground that such a claim falls within the statutory provision permitting judicial review of questions of law that the PRRB lacks authority to decide.

3. Although recent amendments to the Medicare statute have reduced somewhat the importance of the issue regarding the scope of the PRRB's jurisdiction that is presented in this case, the matter remains sufficiently important to warrant review by this Court.

Most hospitals are no longer reimbursed for inpatient services to Medicare beneficiaries solely on the basis of the "reasonable cost" incurred in providing services to Medicare patients. In Title VI of the Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 149-172, Congress adopted the prospective payment system (PPS). Under PPS (which has been implemented over a four-year transition period beginning on October 1, 1983), hospitals are paid predetermined rates for specific services, regardless of the costs incurred by the hospital in providing those services. See 42 U.S.C. (& Supp. III) 1395ww(d), as amended by Pub. L. No. 99-272, § 9102, 100 Stat. 155. Congress adopted PPS primarily "to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices" (H.R. Rep. 98-25, 98th Cong., 1st Sess. 132 (1983)).

Many Medicare providers are not covered by the prospective payment system, however, and continue to obtain reimbursement for their "reasonable" costs by filing cost reports. See 42 C.F.R. 412.20-412.32

(rehabilitation hospitals, psychiatric hospitals, children's hospitals, and hospitals with average length of stay greater than 25 days are not covered by PPS), 413.1 (reasonable cost payment system applies to skilled nursing facilities, home health agencies, and other facilities providing services other than in-hospital care). Moreover, all providers are reimbursed for some categories of costs on a reasonable cost basis. See, *e.g.*, 42 U.S.C. (& Supp. III) 1395ww (a)(4) (anesthesia services provided by nurse); 42 C.F.R. 412.2(d) (capital costs, direct medical education costs, costs for direct medical and surgical services provided by certain physicians in teaching hospitals).[12] Thus, the question presented here regarding the scope of the Board's jurisdiction is a matter of considerable continuing importance.[13]

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[12] In addition, many disputes concerning hospitals' claims for reimbursement under the reasonable cost system are now pending on administrative and judicial review. As the large number of decisions by the courts of appeals addressing this issue shows, the question presented here regarding the scope of the PRRB's jurisdiction arises with some frequency in connection with those claims.

[13] Moreover, the conflict among the courts of appeals presents the Secretary with a difficult administrative problem. The Medicare statute permits a provider to seek judicial review in either the United States District Court for the District of Columbia or the federal district court for the district in which the provider is located (42 U.S.C. (& Supp. III) 1395*oo*(f)(1)). Although the law might be more favorable on the jurisdictional issue in the provider's home district, District of Columbia Circuit precedent on other issues might lead a provider to seek review in the latter district despite the unfavorable law regarding the jurisdictional issue. The Board thus cannot predict with certainty the forum that will be chosen by a particular provider. As a result, there is considerable potential for forum shopping leading to reversal of the Board's determinations and remands for reconsideration of the already-decided cases.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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* The Solicitor General is disqualified in this case.

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